

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1940

Registration District No. _____

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 9768
Registrar's No. 1202

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 18th and Troost Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 years (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Wade B. Boole 40

3. (b) If veteran, No name war _____ 3. (c) Social Security No. No

4. Sex male 5. Color or race Colored 3. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 41 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Mississippi (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation Laborer

11. Industry or business _____

12. Name unknown

13. Birthplace unknown (City, town, or county) _____ (State or foreign country) _____

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant's own signature W. B. Vaughan

(b) Address 1007 Paseo Blvd.

17. (a) Burial (b) Date thereof 3-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director W. B. Vaughan

(b) Address 3-18-40 (Date received local registrar) (b) M. M. Braue (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1007 Paseo Blvd. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: March 6, 1940 3:15-40 day _____ hour _____ minute 50 A M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him/her alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Slab wound 7 chest

Due to _____

Due to 174

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 6

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide

(b) Date of occurrence 3-1-40

(c) Where did injury occur? Kansas City, Mo. (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public

(Specify type of place)

While at work _____ (c) Means of injury _____

23. Signature Russell W. Kern (M. D. or other) _____

Address 6000 Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

AB Maori, Registered Apprentice No. _____,
working under my personal supervision.

Signed AB Maori

Licensed Embalmer No. 2410

P. O. Address 1820 E 18 st

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.